St. Lucie County
Special Needs Registration

Review Date:

Initials:

Please print when completing this application.

APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:
Street Address:	City:	Zip Code:

Gender: ☐ Male ☐ Female	DOB(mm/dd/yyyy):	Home Phone:	Cell Phone:
TDD Notification: ☐ Yes ☐ No		Religious Preference:	

Do you have a service animal: ☐ Yes ☐ No If so, what type:

What work or task has the animal been trained to perform?

RESIDENCE

☐ Mobile/Manufactured ☐ Condominium/Apartment ☐ Single Family/Duplex

Name of Complex/Community:

Are there stairs, elevator, or ramp used to get to your home? ☐ Stairs ☐ Elevator ☐ Ramp ☐ No

CAREGIVER'S INFORMATION

(the person accompanying you to the shelter)

Last Name:	First Name:	Relationship to You:
Street Address:	City:	Zip Code:

Home Phone #:	Cell Phone #:

Notes/Comments:

EMERGENCY CONTACT AND EMERGENCY PLAN

Next of Kin:	Home Phone #:
	Cell Phone #:

Complete Address:

Relationship to You:

If you are unable to return home when the shelter closes, do you have an alternative plan for housing: ☐ Yes ☐ No

If *yes*, please provide the following:

Name/Place:	Complete Address:
Home Phone #:	Relationship (if applicable):
Cell Phone #:	

Have you or your spouse served in the military? ☐ Yes ☐ No

HEALTH INFORMATION

Doctor's Name:	Doctor's Complete Address:
Doctor's Phone #:	

Allergies to Medication/Other: ☐ Yes ☐ No If yes, please explain: _____	Pace Maker: ☐ Yes ☐ No Model: _____

MOBILITY	RESPIRATORY SUPPORT	
☐ I can walk without assistance ☐ I walk with assistance ☐ I use a cane ☐ I use a walker ☐ I use an electric wheelchair/scooter ☐ I use a regular (non-electric) wheelchair ☐ I can transfer myself from a wheelchair to a vehicle seat. ☐ I require the use of a lift ☐ I am bedridden - **If so, how much do you weigh? _____ How tall are you? _____**	☐ I use oxygen support and understand that I must bring my supply. Oxygen Supplier: _____ Phone#:_____	_____ Hours per day _____ Liter flow ☐ Liquid ☐ Concentrator
	☐ I use a nebulizer & understand that I must bring my nebulizer.	_____ Times per day

Hospice: ☐ Yes ☐ No Hospice Name:

DIALYSIS

Name of Dialysis Center:

Address:

Phone #: Schedule:

Medication List (add additional sheet if needed)

Prescription Medications			Over-the-Counter (OTC) Medication		
Rx Name	**Dose**	**How Often**	**OTC Name**	**Dose**	**How Often**

Insurance Information and ID number

☐ Medicare:_____ ☐ Medicaid:_____

☐ Champus:_____ ☐ Private Insurance:_____

☐ TriCare for Life:_____ ☐ Other:_____

TRANSPORTATION

(please check appropriate needs)

☐ I need transportation and medical attention
☐ I need transportation only (I have no way to get to a shelter)
☐ I need medical attention only (I have transportation)

Medical Needs Criteria (check all that apply)

- ☐ I am dependent upon a health professional to administer injectable medications
- ☐ I require daily or more frequent dressing changes by a health care professional.
- ☐ I need assistance by a health care professional with ostomy management, continuous peritoneal dialysis or indwelling catheters of any kind
- ☐ I have daily activities that are so restricted by immobility that my basic medical needs must be met by others.
- ☐ I require daily assessment of unstable medical condition by professional nursing personnel, (i.e., diabetes, cardiac, cystic fibrosis.
- ☐ I am a terminally ill patient who needs professional assistance for administering heavy doses of Medication
- ☐ I am a resident whose life depends upon electrically energized equipment within my residence (i.e., suction machines, home dialysis machines, O2 concentrators) excluding electric wheelchair without other qualifying conditions
- ☐ I depend on oxygen therapy
- ☐ I am bedridden and require custodial care upon advice of a personal physician. (As per Florida Statutes, it does not necessarily mean assigned to a special needs medical facility. Other facilities such as nursing home or hospitals will be utilized).

IMPORTANT

If you have checked any of the medical needs criteria, please complete the following questions.

1. **Do you currently have a home health nurse coming to your home? ☐ Yes ☐ No**
2. **If yes, Name of agency _____**
3. **If no, Name of person providing care _____**
4. **Specially what type of care are you now receiving? Please be very specific.**

_____

_____

Signature: _____ Date: _____

☐ *To the best of my knowledge, I certify that this information contained herein is true and correct.*

FOR OFFICIAL USE ONLY

Fenn Center ☐ Alternate Shelter ☐ Lawnwood ☐ Pre-Registered ☐

Shelter Section: _____ Bed #: _____

Transportation Type _____ Medical Needs _____ Transport _____

Zone: _____ Plant Evacuation Area: _____

Check In Date/Time: _____ Check Out Date/Time: _____

Mail Completed Form to:

St. Lucie County Public Safety & Communications
15305 W. Midway Road
Fort Pierce FL 34945
Office: (772) 462-8100
Fax: (772) 462-2308

Please Keep the Information Below For Your Information*

Essential Items You Must Bring To the Medical Shelter

1. Pillow, blanket and linens. The caregiver should bring a fold up cot, twin size air mattress, or equivalent. The caregiver should bring a pillow, blanket, and linens.

2. Three day supply of non-perishable food for individual taste and/or special diet per person.

3. Three day supply of drinking water in non-breakable container(s). (1 gallon per day, per person)

4. Prescription medications in their prescription bottles.

5. Medical supplies.

6. Vital medical equipment i.e. oxygen concentrators, portable oxygen bottles.

7. Personal Items:

    a. Important papers (Personal identification, Insurance policies, Etc)

    b. Reading Glasses

    c. Personal hygiene articles (tooth brush, soap, towel, wash cloth)

    d. Change of clothing

    e. Sweater or jacket

    f. Rainwear

    g. Flashlight with extra batteries

    h. Quiet games i.e. cards, book, and knitting